Standard Funding Questions for SPA 11-013

The following questions are being answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B of this SPA. For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners, these questions must be answered for all payments made under the state plan for such service.

Question #1: Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

Response: SPA 11-013 is limited in scope to changing benefits. Pages 6B and 6C of Attachment 4.19-B are being amended only to make conforming amendments to the references to federally qualified health center (FQHC) and rural health clinic (RHC) services that are eligible for reimbursement under Pages 6 through 6S.

SPA 11-013 does not change the methods and standards used for setting payment rates. The amounts that are used in the rate setting methodologies and formulas may be impacted, but the formulas and other prescribed calculations are not being changed. FQHCs and RHCs are required to submit scope-of-service changes when a change in their scope of service results in an average per visit rate decrease in excess of 2.5 percent. A scope-of-service change could result in changes to the FQHC's or RHC's prospective payment system (PPS) reimbursement rate per visit, but would not result in changes to any applicable methods or standards for setting rates.

Accordingly, this question #1 is not applicable to this SPA submission.

Question #2: Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan.

Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

i. a complete list of the names of entities transferring or certifying funds;
ii. the operational nature of the entity (state, county, city, other);
iii. the total amounts transferred or certified by each entity;
iv. clarify whether the certifying or transferring entity has general taxing authority; and,
v. whether the certifying or transferring entity received appropriations (identify level of appropriations).

Response: Please refer to the response for Question 1.

Question #3: Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

Response: Please refer to our response for Question 1.

Question #4: For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned

or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.

Response: Please refer to our response for Question 1.

Question #5: Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

Response: Please refer to our response for Question 1.